DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 16 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7826

Registration District No. 4425

Primary Registration District No. 713

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39
1 X19511

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Waynesville, Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pulaski
(c) City or town Waynesville, Mo (If outside city or town limits, write "RURAL")
(d) Street No. 0 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME SARAH (FARQUER) REED
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex Fem.
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife George W. Reed
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. (Month) 1 (Day) 1860 (Year)

8. AGE: Years 79 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation Housekeeper
11. Industry or business
12. Name of FATHER Samuel Stonemets
13. Birthplace Rome (City, town, or county) Indiana (State or foreign country)
14. Maiden name of MOTHER Olive Leeds
15. Birthplace Batavia (City, town, or county) Ohio (State or foreign country)
16. (a) Informant's own signature Jessie Farquer Rothgus
(b) Address 4119 E 32nd Ave Cincinnati, Ohio
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/6/40 (Month) (Day) (Year)
(c) Place: burial or cremation Cincinnati, Ohio
18. (a) Signature of funeral director C. L. Casey
(b) Address Waynesville, Mo
19. (a) 3/5/40 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 year 1940 hour 2 minute 40 A.M.

21. I hereby certify that I attended the deceased from Feb. 22, 1940, to March 5, 1940, that I last saw h[illegible] alive on March 4, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	3 days
Due to:	
Due to: Flu	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) By Means of injury

23. Signature C. A. Aldhizer (M. D. or other)
Address Waynesville Date signed 3/5/40

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Laran Adams, Registered Apprentice No. 211,

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 340292

Date Filed 3/24/40

Signed G. LeCasey

Licensed Embalmer No. 2694

P. O. Address Ironia, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
1-2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7826

Registration District No. 713 Primary Registration District No. 4428 Registrar's No.

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Waynesville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. A
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Sarah F Reed
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 79 Months 7 Days 4 If less than one day hr. min.

9. Birthplace Cincinnati (City, town, or county) Ohio (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 3/5/1940 (Date received local registrar) (b) O R Talbot (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 3
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature O. A. Talbot (M. D. or other)
Address Waynesville Date signed